USAO#2004R01221/LR

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA	:	Hon.
v.	:	Crim. No. 07-
JOHN CAVALLI and ALAN TUCHMAN	:	18 U.S.C. §§ 1347, 1349 and 2

I N D I C T M E N T

The Grand Jury, in and for the District of New Jersey, sitting at Newark, charges:

COUNT ONE

(Health Care Fraud)

THE DEFENDANT

1. At all times relevant to this Indictment, defendant JOHN CAVALLI was a podiatrist licensed to practice in the State of New Jersey, and was the President and Chief Executive Officer of the Poor Circulation Treatment Center, a/k/a Poor Circulation Center ("PCTC"). PCTC was a podiatry practice in Mercer County, New Jersey.

BACKGROUND

2. At all times relevant to this Indictment:

a. A podiatrist was required to be licensed by the state in which he or she practiced. Podiatry was a limited practice specialty. A doctor of podiatric medicine was included within the definition of a physician, but only with respect to

those areas within the scope of his or her license. A doctor of podiatric medicine had a limited license to treat conditions from the lower leg to the foot. A podiatrist was permitted to make diagnoses, treat patients, perform surgical procedures, take x-rays and prescribe medication.

b. PCTC specialized in wound and circulatory care for podiatric patients. A large portion of the patients treated by PCTC was elderly and poor, and PCTC received payments for many of the services it performed from the Medicare Program ("Medicare") and from private health insurers.

The Medicare Program

3. At all times relevant to this Indictment:

a. Medicare was a federal health insurance program established by the Social Security Act of 1965, codified as amended in various sections of Title 42 of the United States Code, to provide medical services, medical equipment, and supplies to aged, blind, and disabled individuals who qualified under the Social Security Act ("beneficiaries"). Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency within the United States Department of Health and Human Services. The Medicare Part B program was a federally-funded supplemental insurance program that provided supplementary Medicare insurance benefits for individuals aged 65 or older and certain individuals who were disabled. The Medicare

Part B program paid for medical services, including podiatry and physical therapy services, for beneficiaries. Under this program, Medicare paid a large percentage of the costs associated with medical services provided to beneficiaries, that is, approximately 80 percent of the total for which a health care provider submitted a claim.

b. Medicare required health care providers to complete an enrollment application and be approved to participate as a provider in the program. Once approved, the provider was assigned a unique Medicare provider number. Upon enrollment and periodically thereafter, each Medicare provider was furnished with information relevant to participating in the program and how to bill for services rendered. Each claim for payment, commonly referred to as "reimbursement," submitted on behalf of a health care provider – whether in paper form or electronically – was required to identify the claimant's Medicare provider number.

c. Claims submitted to Medicare required the provider to state a diagnosis of the patient's condition and to provide a Current Procedure Terminology code ("CPT code") identifying the service or services rendered. Specifically with regard to therapeutic procedures, CPT codes also denoted whether the procedure was rendered in a direct physician to patient "one-on-one" contact, or in a "group" setting consisting of two or more individuals. CPT codes were established, defined and published

by the American Medical Association. Medicare required the provider to certify that the services rendered were medically necessary and were furnished by the physician who submitted the claim. Medicare required further that the services were rendered consistent with its rules, regulations and policies, many of which were governed by the applicable state's laws and regulations. The provider was also required to certify the location and dates the services were rendered. Providers participating in Medicare were required to agree in writing that they would be responsible for the accuracy of all claims submitted by them, their employees or agents, and that all claims submitted under their provider numbers were accurate, complete and truthful.

d. The remaining cost of medical services performed that was not covered by Medicare, that is, approximately 20 percent, was usually paid for by the beneficiary's secondary insurance carrier if a beneficiary had such insurance. In cases where a beneficiary had such secondary insurance, the medical provider submitted a claim to both Medicare and the secondary insurance provider. In cases where the beneficiary had no secondary insurance, the medical provider billed the patient directly for the 20 percent co-payment.

e. CMS contracted with private insurance carriers to administer Medicare in the particular geographic area where the

services were provided. Medicare providers forwarded claims for services covered by Medicare to these designated private insurance carriers. Empire Medicare Service ("EMS") processed and handled the payment of Medicare Part B claims submitted by Medicare providers or suppliers of services in the State of New Jersey. EMS was also responsible for conducting audits and on-site inspections of providers to ensure compliance with Medicare regulations and for providing manuals and other documents that describe Medicare Part B coverage requirements.

The Circulator Boot

4. At all times relevant to this Indictment, the Circulator Boot ("CB") was a device approved by the U.S. Food and Drug Administration to treat a variety of circulatory and podiatric medical problems. The CB procedure was not, however, an authorized treatment protocol in New Jersey for wound care or poor circulation under Medicare regulations, which deemed such use of the CB as "not medically necessary."

Electrical Stimulation

5. At all times relevant to this Indictment, electrical stimulation ("E-Stim") was a form of physical therapy which used an electrical current to cause a single muscle or a group of muscles to contract. According to New Jersey state regulations, only qualified professionals, such as physicians or licensed physical therapists, were permitted to provide E-Stim therapy.

Prepayment Review

6. At all times relevant to this Indictment, prepayment review was a process whereby EMS closely scrutinized claims to ensure compliance with its rules, regulations and policies and with federal laws and regulations consistent with national Medicare policies. During prepayment review, EMS reviewed each claim for reimbursement on a case-by-case basis, requiring the provider of the service to completely document the medical need for the service.

The Private Health Insurance Carriers

7. At all times relevant to this Indictment, Horizon Blue Cross Blue Shield of New Jersey ("Horizon") and Aetna Life Insurance Company ("Aetna") were private health insurance carriers licensed by the State of New Jersey to provide health care coverage to individuals contracting for such services. Horizon and Aetna therefore could be a beneficiary's secondary insurance carrier. Defendant JOHN CAVALLI was an approved Medicare provider and billed Medicare, via EMS, for services purportedly rendered. Defendant JOHN CAVALLI also submitted claims to Horizon and Aetna.

THE HEALTH CARE FRAUD

8. From at least as early as in or about January 2001 to in or about January 2003, in Mercer County, in the District of New

Jersey, and elsewhere, defendant

JOHN CAVALLI

did knowingly and willfully execute and attempt to execute a scheme and artifice (1) to defraud, and (2) to obtain, by means of false or fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, health care benefit programs, that is, the Medicare Program, Horizon Blue Cross Blue Shield of New Jersey and Aetna Life Insurance Company, in connection with the delivery of and payment for health care benefits, items, and services as set forth below.

9. Among the manner and means used by defendant JOHN CAVALLI to carry out the health care fraud scheme set forth above were those set forth in Paragraphs 11 through 16 below.

Services Rendered

10. Various podiatric and therapeutic services were rendered to patients at PCTC by defendant JOHN CAVALLI and/or unqualified personnel as follows:

a. Defendant JOHN CAVALLI personally rendered a small number of podiatric services to PCTC patients for which he submitted claims for reimbursement to Medicare, Horizon and Aetna (collectively, the “health care insurers”). Defendant JOHN CAVALLI billed the health care insurers for these services commensurate with the podiatric treatment rendered.

b. Most of the services rendered to PCTC patients

involved therapeutic services, such as the CB procedure and E-Stim. In most instances, these services were rendered by unqualified personnel, who had received little or no professional training, at PCTC or elsewhere, to properly provide such therapies. Defendant JOHN CAVALLI submitted false and fraudulent claims for these services in that the claims were submitted as though defendant JOHN CAVALLI had personally rendered the services. In addition, in many instances these services were rendered outside the presence of defendant JOHN CAVALLI contrary to New Jersey state laws and regulations.

11. In addition to the use of unqualified personnel, defendant JOHN CAVALLI utilized other schemes to defraud the health care insurers in the submission of claims for therapeutic services including, but not limited to, the submission of not medically necessary services and the submission of upcoded claims.

Submission of Claims for Not Medically Necessary Services

12. On numerous occasions, defendant JOHN CAVALLI rendered or caused to be rendered the CB procedure to patients at PCTC to treat poor circulation, and submitted claims for reimbursement for these services to the health care insurers, knowing that the services were not eligible for reimbursement. For example, defendant JOHN CAVALLI knew that when he used the CB procedure for wound care or to treat poor circulation, EMS required him to

bill CPT code 93799 even though the claim would then be denied as not medically necessary. This billing procedure enabled EMS to adequately track the medical care rendered to its beneficiaries. Instead, defendant JOHN CAVALLI billed for the CB procedure using CPT code 97110, denoting a one-on-one physical therapy service. Billing in this manner was fraudulent not only because the service was not medically necessary, but also because the service was rendered by unqualified personnel in a group setting and not on a one-on-one provider-to-patient basis as billed.

Submission of Upcoded Claims

13. On numerous occasions, defendant JOHN CAVALLI submitted claims to the health care insurers under CPT code 97032, a code utilized for one-on-one, constant attendance, E-Stim therapy. However, the E-Stim therapy actually rendered was an unattended service which should have been billed under a different CPT code at a lower rate of reimbursement. This practice, commonly referred to as “upcoding” of claims, resulted in the receipt of a higher reimbursement than was otherwise proper. In addition, in most cases, unqualified personnel administered the E-Stim therapy outside the presence of defendant JOHN CAVALLI. Had the health care insurers known that the administration of unattended E-Stim therapy was actually rendered by unqualified personnel, the insurers would have denied such claims entirely.

Obstruction of Medicare's Prepayment Review Process

14. From on or about February 19, 2002 through in or about October 2002, defendant JOHN CAVALLI obstructed Medicare's prepayment review process by misrepresenting the CB procedure as various physical therapy modalities enabling defendant JOHN CAVALLI to receive reimbursement from Medicare. Each time defendant JOHN CAVALLI was placed on prepayment review for one code, he billed the CB procedure under another code, and was reimbursed for services under the new code.

15. In or about February 2002, EMS received information that defendant JOHN CAVALLI exceeded his peers in billing CPT codes 97032 and 97110. In response, EMS generated a statistically valid random sample of defendant JOHN CAVALLI's Medicare claims. In so doing, EMS requested and received from defendant JOHN CAVALLI a sampling of patient records from on or about January 2, 2001 through on or about October 30, 2001. The majority of these services were in fact for use of the CB procedure to treat poor circulation, which was not an EMS covered service, and E-Stim therapy, which, although a covered service, was not rendered according to existing policies and regulations. EMS deemed most of these services as not medically necessary and, as such, would have denied the claims had they not already been paid. EMS then placed defendant JOHN CAVALLI on prepayment review, on three different occasions, for four different CPT

codes as follows:

a. On or about February 19, 2002, EMS informed defendant JOHN CAVALLI that he was being placed on prepayment review for CPT code 97110, under which code he had previously billed nearly all the CB treatments administered to PCTC's patients. Sometime thereafter, defendant JOHN CAVALLI stopped using CPT code 97110 when billing for the CB procedure and began using CPT code 97150, a code indicating that physical therapy was administered to patients in a group setting. Until that time, defendant JOHN CAVALLI had not billed CPT code 97150 and, as such, was not under prepayment review for that code.

b. On or about May 1, 2002, EMS placed defendant JOHN CAVALLI on prepayment review for CPT codes 97150 and 97032. Defendant JOHN CAVALLI then switched from these codes to CPT code 99199 to bill for the use of the CB procedure. CPT code 99199 was designated as a "catch-all" code to capture otherwise unlisted procedures. At the time, defendant JOHN CAVALLI was not under prepayment review for CPT code 99199.

c. On or about October 10, 2002, EMS notified defendant JOHN CAVALLI that he was being placed on prepayment review for CPT code 99199. Thereafter, defendant JOHN CAVALLI continued to use the CB procedure with his patients, but misrepresented the services that were rendered to these patients in bills submitted to Medicare by claiming one type of service,

such as massage therapy or an office visit, when, in fact, the CB procedure was the service rendered.

The Loss Amounts Sustained by the Health Care Insurers

16. In all, by the above means, defendant JOHN CAVALLI obtained more than $1,000,000 from Medicare, and more than $180,000 from Horizon and Aetna combined, in payment on the fraudulent claims.

In violation of Title 18, United States Code, Sections 1347 and 2.

COUNT TWO

(Conspiracy to Commit Health Care Fraud)

1. Paragraphs 1 through 7 and 9 through 16 of Count One are re-alleged and incorporated herein by reference.

2. In or about December 2002, defendant JOHN CAVALLI was placed on prepayment review for all CPT codes for which he could seek reimbursement, and discontinued submitting claims to Medicare for most therapeutic services. Thereafter, as described more fully in Paragraphs 8 through 17 below, defendant JOHN CAVALLI conspired with other podiatrists to defraud Medicare by having those podiatrists bill Medicare for services rendered to defendant JOHN CAVALLI's patients at PCTC.

THE CONSPIRATORS

3. In or about December 2002, defendant JOHN CAVALLI solicited various podiatrists ("the affiliated podiatrists"), including defendant ALAN TUCHMAN, to work at PCTC. Defendant ALAN TUCHMAN and the affiliated podiatrists did not draw a salary from PCTC, instead receiving a portion of the proceeds from the practice when finances allowed.

4. At all times relevant to this Indictment, defendant ALAN TUCHMAN and the affiliated podiatrists were licensed to practice in the State of New Jersey and were approved Medicare providers. Neither defendant ALAN TUCHMAN nor any of the affiliated podiatrists was the subject of prepayment review. Defendant ALAN

TUCHMAN and the affiliated podiatrists also submitted claims to Horizon and Aetna. As such, they possessed their own valid Medicare provider numbers and tax identification numbers for Horizon and Aetna.

THE CONSPIRACY

5. From in or about January 2003 to in or about January 2005, in Mercer County, in the District of New Jersey, and elsewhere, defendants

JOHN CAVALLI and
ALAN TUCHMAN

did knowingly and willfully conspire and agree with each other and with others to execute a scheme and artifice (1) to defraud, and (2) to obtain, by means of false or fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, health care benefit programs, that is, the Medicare Program, Horizon Blue Cross Blue Shield of New Jersey and Aetna Life Insurance Company, in connection with the delivery of and payment for health care benefits, items, and services, contrary to Title 18, United States Code, Section 1347.

OBJECT OF THE CONSPIRACY

6. It was the primary object of the conspiracy to obtain payment from the health care insurers by submitting false and fraudulent claims for reimbursement to which the conspirators were not entitled.

MANNER AND MEANS OF THE CONSPIRACY

7. Among the manner and means used by defendants JOHN CAVALLI and ALAN TUCHMAN and the affiliated podiatrists (collectively, "the conspirators") to carry out the conspiracy and effect its unlawful object were those set forth in Paragraphs 8 through 17 below.

Services Rendered

8. Various podiatric and therapeutic services, which had been rendered to patients at PCTC by defendant JOHN CAVALLI and/or unqualified personnel in preceding years, continued to be rendered by defendant ALAN TUCHMAN and the affiliated podiatrists as follows:

a. Defendant ALAN TUCHMAN and the affiliated podiatrists personally rendered a small number of podiatric services to defendant JOHN CAVALLI's patients at PCTC for which they submitted claims for reimbursement, commensurate with the podiatric treatment rendered, to the health care insurers.

b. In most instances, therapeutic services, such as the CB procedure and E-Stim, were rendered to defendant JOHN CAVALLI's patients at PCTC by unqualified personnel. Defendant ALAN TUCHMAN and the affiliated podiatrists submitted false and fraudulent claims for these services in that the claims were submitted as though the podiatrists had personally rendered the services. In many instances, these services were rendered by

unqualified personnel outside the presence of any licensed podiatrist, contrary to New Jersey state laws and regulations.

9. Defendant JOHN CAVALLI also caused other "treatments," such as the use of stationary bicycles and treadmills, to be administered to patients at PCTC in conjunction with the CB procedure. The conspirators billed the health care insurers for these purported therapeutic activities which, in most instances, were administered by unqualified personnel.

10. In addition to the use of unqualified personnel, the conspirators also utilized several other schemes to defraud the health care insurers in the submission of claims for therapeutic services including, but not limited to, the misrepresentation of services; the submission of claims for not medically necessary services; and the submission of upcoded and otherwise unreimburseable claims. The billing for services rendered to defendant JOHN CAVALLI's patients at PCTC by defendant ALAN TUCHMAN and the affiliated podiatrists also circumvented the Medicare prepayment review process audit of defendant JOHN CAVALLI.

Misrepresentation of Services

11. As had been defendant JOHN CAVALLI's practice in preceding years, the conspirators misrepresented the nature of the services rendered to patients in order to deceive the health care insurers and obtain reimbursements to which they were not

entitled. For example, the conspirators billed for one-on-one physical therapy modalities when, in fact, the patients at PCTC were treated in a group environment, not individually, as the claims purported.

Submission of Claims for Not Medically Necessary Services

12. The conspirators rendered or caused to be rendered the CB procedure to patients at PCTC to treat poor circulation, and submitted claims for these services to the health care insurers knowing that the services were not eligible for reimbursement, in the same manner that defendant JOHN CAVALLI had done in preceding years.

13. The conspirators also rendered or caused to be rendered physical therapy services to patients at PCTC when such services did not rise to the level of accepted physical therapy practice. For example, in some instances, the unqualified personnel merely rubbed the feet and legs of patients diagnosed with poor circulation for a de minimus period of time. As a result of that "treatment," the conspirators submitted claims to the health care insurers seeking reimbursement for massage therapy when, in fact, patients merely received a short leg and foot rub.

Submission of Upcoded Claims & Otherwise Deniable Claims

14. The conspirators submitted claims to the health care insurers seeking reimbursement for one-on-one constant attendance E-Stim therapy. However, the E-Stim therapy rendered was an

unattended service which should have been billed under a different CPT code at a lower rate of reimbursement. In addition, in most cases, unqualified personnel had administered the E-Stim therapy outside the presence of any licensed podiatrist, as had been defendant JOHN CAVALLI's practice in preceding years. Had the health care insurers known that the administration of unattended E-Stim was actually rendered by unqualified personnel, they would have denied such claims entirely.

Use of Affiliated Podiatrists
to Circumvent the Medicare Audit

15. The submission of bills by defendant ALAN TUCHMAN and the affiliated podiatrists also circumvented the prepayment review process. In order to circumvent this process, the conspirators agreed that defendant JOHN CAVALLI would refer his patients to defendant ALAN TUCHMAN and the affiliated podiatrists for the rendering of services at PCTC. Defendant JOHN CAVALLI instructed defendant ALAN TUCHMAN and the affiliated podiatrists to submit reimbursement claims for services to Medicare under their own Medicare numbers and to Horizon and Aetna under their own tax identification numbers.

16. Defendant JOHN CAVALLI further instructed defendant ALAN TUCHMAN and the affiliated podiatrists as to which specific CPT codes to bill and which diagnoses to indicate on the health care insurers' forms. The submission of claims under the

provider numbers of defendant ALAN TUCHMAN and the affiliated podiatrists prevented EMS from adequately auditing and reviewing the services rendered to defendant JOHN CAVALLI's patients during the prepayment review period.

17. Defendant ALAN TUCHMAN and the affiliated podiatrists agreed to share with defendant JOHN CAVALLI reimbursements from the health care insurers in connection with services rendered to patients at PCTC, which patients had been referred to them by defendant JOHN CAVALLI. After receiving payments by check from the health care insurers, defendant ALAN TUCHMAN and the other affiliated podiatrists deposited the reimbursement checks into their own personal and/or business accounts. In some cases, defendant ALAN TUCHMAN and the affiliated podiatrists then issued checks to defendant JOHN CAVALLI and/or PCTC for the total amount of reimbursement received for those services purportedly rendered to patients at PCTC. Defendant JOHN CAVALLI agreed to reimburse defendant ALAN TUCHMAN and the affiliated podiatrists for up to 30 percent of that total, but only as finances allowed. In other instances, defendant ALAN TUCHMAN and the affiliated podiatrists deposited the reimbursement checks into their personal and/or business accounts and remitted checks to defendant JOHN CAVALLI and/or PCTC in specified amounts.

The Loss Amounts Sustained by the Health Care Insurers

18. In all, by the above means, the conspirators obtained more than $200,000 from Medicare, and more than $18,000 from

Horizon and Aetna combined, in payment on the fraudulent claims.

In violation of Title 18, United States Code, Section 1349.

A TRUE BILL

_____
FOREPERSON

_____
CHRISTOPHER J. CHRISTIE
UNITED STATES ATTORNEY